CHILDREN'S SPECIAL HEALTH AND DENTAL SERVICES APPLICATION

| Name: | | | | | | | Date of E | Birth: | | |
|-----------|-------------------------|---|---------------------|-----------------|--------------|---------|-----------------|----------------------|-----------|-------|
| | Last | | First | | MI | | | | | |
| Check | Program(s) C | lient is Applying For | r: □CSH □H | IRM □NBIC | ☐ Dental | □Cri | ppling Malo | cclusion | e | |
| Tier Le | evel: 1 2 | | | | | Referr | al Date: | | | |
| | (Circle | e) | | | | Eligib | ility Date Re | quested: | | |
| | | rimary Care Provide | | | | | | | | |
| next to | the current or | ce (RS) column below potential provider(s | s) where the client | t may be referi | ed. Choose | Provi | der Type Co | de from the list bel | ow. Fo | r the |
| | al Records Fie PHN). | ld (MR) choose 1 (1 | Not applicable), 2 | (Enclosed), 3 | (Requested | but not | t received), o | r 4 (CSH to request | and ser | ıd |
| RS | | <i>Tull Name</i> , Address | and Phone | Provider | Diagnosi | s/ 1 | Date of Last | Date of Next | į | MR |
| | Number | | | Type Code | Symptom | | Appointment | | | |
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| <u>If</u> | needed, list R | <u> Celevant Providers w</u> | ho may be able t | o provide pert | inent histor | y on th | e client's con | ndition: | | |
| Provid | der's Full Nai | ne , Address and Pl | ione Number | | | | <u>Provider</u> | Date Last Seen | <u>MR</u> | |
| | | | | | | | Type Code | | | |
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| Provi | der Type Cod | les: | | | | | | | | |
| 1. Auc | Ü | ε | 7. Geneticist | 10. Orthodo | ntist 13. | Pulmor | nologist 16. | Physical Therapist | | |
| | • | 5. Speech Therapist | _ | 11. Orthopa | | Urolog | | Surgeon - What Type | | |
| 3. Der | | 6. Gastroenterology | Ophthalmologis | t 12. Pediatric | eian 15. | ENT | 18. | Other: | | |
| Conti | nued on Back | Σ. | | | | | | | | |

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CHILDREN'S SPECIAL HEALTH AND DENTAL SERVICES APPLICATION (cont)

| Are there siblings on CSH? Yes \square No \square If ye | s, please print their names(| s) and Case # ('s) |
|---|------------------------------|--------------------|
| Has client applied for CSH within the past two years? | Yes □ No □ | |
| Other Programs: | | |
| Is the client on SSI? Yes \Box No \Box | <i>SSI#</i> | |
| Is the client on The Children's Medicaid Waiver? | Yes □ No [| |
| If yes, who is the Individual's Service Coordinator (ISO | C)? | |
| Special Re | equest(s): | |
| Specialty Clinic(s) | | |
| Location of Clinic | | |
| Location of Clinic | | |
| Travel Assistance Yes □ No □ | | |
| Other Special Requests | | |
| | | |
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| | | |
| Care Coordinator's Signature | County | |